C-14

Claim No.....

STATE OF NEW JERSEY, ACCIDENT BLANK

Report every accident, no matter how small, and in case of fatal accident or serious injury, telephone or telegraph at once, giving date of inquest, if any. A compensable occupational disease is to be considered an accident.

This report of accident or occupational disease is to be prepared in TRIPLICATE. The original is to be sent to the Department of Labor, Bureau of Industrial Statistics, State House, Trenton, N. J. Carbon copy will not serve. Triplicate copy is to be kept on file by the employer. Duplicate copy is to be sent to

THE EMPLOYERS' LIABILITY ASSURANCE CORPORATION, LTD.
1180 Raymond Boulevard - Raymond-Commerce Building
Newark, N. J.

FORM "C". First notice of Accident. For use by insuring employers.

.....
(Name of Employer)

.....
(Street Address)

.....
(City or Town)

.....
(Business)

Date report received
Leave this line blank.....

Date of Accident
Number of Month 9
Day of Month 12
Year 43
A. M.
P. M.
Hour

(Name of Injured Employee) Albert McLeans
(Street Address) 93 Myrtle St
(City or Town) Orchard

3. (Occupation)
4. (Nationality)
5. Sex Male 6. Age 23 7. Married.....

1. State fully how accident occurred..... left elbow sprained while pitching ball

2. Exact part of person injured, with nature and extent of injury.....

Was amputation necessary?.....

12. Give probable period of disability.....
13. Was medical attention necessary?.....
14. Name and address of attending physician..... Dr Baeta Barclay St Newark N J
15. If sent to hospital, state name and location.....
16. Exact location of accident. If away from plant, give town, street and number..... Triple Field Baseball Park Baltimore
Date of preparing this blank..... Aug 20 ..... 19..43.....

8. Give name of machine or appliance involved.....
9. Indicate kind of work done on this machine.....
10. Name distinct part of machine causing injury.....
11. Was any guard protecting this portion of the machine?.....
17. Were the wages fixed by the output?.....
18. If the wages were fixed by the hour, state RATE per hour.....
19. Give number of HOURS in ordinary day.....
20. Give number of DAYS in ordinary working week.....
21. State the amount of weekly WAGES.....
Made out by.....

Before detaching, fill in on FORM "D" names, date of accident, and mail seven days after.
If employee has resumed work at time of reporting, do not detach.

.....
(Name of Employer)

.....
(Street Address)

.....
City or Town)

Date of Accident

Number of Month.....

Day of Month.....

Year.....

(Name of Injured Employee)

(Street Address)

(City or Town)

30. Did employee lose any time? No

31. Date disability began.....

32. Is employee able to resume work?.....

33. If so, on what DATE? .....

34. State length of disability, weeks.....days.....

Date of preparing this blank..... Aug 20 .....19 43

35. Date seven days after accident.
Must be mailed on or before.....

36. Report received.
Leave this blank.....

37. If not able to work, give
probable date of recovery.....

38. Has any permanent injury resulted?
If so, describe fully on back of form.....

Made out by.....

If employee is still disabled at the time of preparing FORM "C", fill in names on this supplemental report, detach it and forward same, duly completed, on the SEVENTH DAY after the day of the accident, or on the day the injured returns, if he is able to work before the expiration of seven days. *If employee loses no time*, or has returned to work at time of reporting, fill out FORM "D", but do not detach.

This report of accident is to be prepared in TRIPLICATE. Mail the original (if detached) to the Department of Labor, Compensation Bureau, State Office Building, Trenton, N. J. (carbon copy will not serve). Triplicate copy is to be kept on file by the employer. Duplicate copy is to be sent to

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1180 Raymond Boulevard - Raymond-Commerce Building

Newark, N. J.

FORM "D". SUPPLEMENTAL REPORT. For use of insuring employers. When in need of blanks, apply to your insurance carrier.

13856 Rev.